Appendix 7

Medicaid Guidelines and Performance Measurements for Prenatal Care Coordination

The following pages provide guidelines with which prenatal care coordination (PNCC) agencies are required to comply when providing PNCC services. The document is divided into seven sections:

I. Prenatal Care Coordination Administration.
II. Pregnancy Questionnaire Administration.
III. Care Plan Development.
IV. Ongoing Prenatal Care Coordination and Monitoring.
V. Nutrition Counseling.
VI. Basic Health Information and Health Education.
VII. Postpartum Services.

Benefit guidelines are listed in the left-hand column of each page, while performance measurements are in the right-hand column. Wisconsin Medicaid uses the performance measurements to determine if the provider is complying with the benefit guidelines. If a guideline is not met, the provider is required to have written documentation that it has a reasonable alternative in place.

I. Prenatal Care Coordination Administration

GUIDELINE The provider must:	PERFORMANCE MEASUREMENT
I.A. Develop a plan which addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform potentially eligible pregnant women about the availability of PNCC services. At a minimum, the plan must: • Identify the provider's target population (for example, teens only, all eligible recipients in the county, recipients in specific ZIP codes). • Outline the strategies that will be used to inform eligible recipients, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of PNCC services. Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.	**I.B.** The provider is required to have an outreach plan available for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about PNCC services.
I.C. Establish written procedures to ensure that care coordinators include recipients, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: • Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 30 days, at a minimum.

GUIDELINE (I.D. Cont.)	PERFORMANCE MEASUREMENT
• Accuracy, legibility, and completeness of records (for example, the accurate scoring of Pregnancy Questionnaires, the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a recipient). • Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. • Procedures to ensure that recipients are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services. • Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. • Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 30 days, at a minimum. • Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each recipient. The number of clients per care coordinator will vary depending on the needs of the recipients on their caseload. • The provision of services by culturally competent staff. • The provision of services that are family centered. • Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: • The staff responsible for oversight of the policies and procedures. • Steps for prioritizing, monitoring, and correcting problem areas.	

GUIDELINE	PERFORMANCE MEASUREMENT
I.E. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.E.** The provider has written procedures requiring the review by and signature of qualified professionals of all Pregnancy Questionnaires completed by paraprofessionals.
I.F. Develop a written plan for providing timely, non-disruptive, translator services for recipients who are hearing impaired and for recipients who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Pregnancy Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.F.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the provider has a current list of "on call" interpreters available for review.
I.G. Develop written procedures for scheduling recipients for the initial assessment, initial care plan development, ongoing care coordination and monitoring services, and health and nutrition education, if appropriate. The schedule should allow adequate time with each individual to address her problems, develop a plan of action, and provide adequate education. If possible, schedule the initial assessment within 10 working days after the request for a service by a pregnant woman, or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Pregnancy Questionnaire and care plan are completed.	**I.G.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.H. Develop written procedures for following up with recipients who fail to keep appointments (care coordination, social service, prenatal or other appointments). Include time frames within which the recipient must be contacted and the steps designed to help the recipient keep future appointments.	**I.H.** Written procedures that meet the stated guidelines are available for review.
I.I. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies: • Adoption. • AIDS/HIV.	**I.I.** A current list of appropriate community resources - including, but not limited to, the services and agencies stated in the guidelines - and addresses, telephone numbers, and any associated costs is on file.

GUIDELINE	PERFORMANCE MEASUREMENT
(I.I. Cont.) • Adult protective services. • Alcohol, tobacco, and other drug abuse. • Child welfare services. • Children with special health care needs program. • Day care centers. • Domestic/family violence. • Early childhood intervention programs (for example, Head Start, Birth to 3). • Education. • Employment/job training. • Family planning. • Food pantries/other food services. • Special Supplemental Food Program for Women, Infants, and Children (WIC) programs. • Housing and shelters for the homeless. • Legal assistance. • Social services (e.g., family/marriage counseling, family support services, clothing for newborns). • Parenting education (including fathers). • Perinatal loss/grief counseling. • Respite/family resource centers. • Transportation. The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.	
I.J. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the referrals from these agencies and providers. Ensure that staff are aware of these agreements. Medicaid HMOs are required to sign a Memorandum of Understanding (MOU) with all PNCC providers in their service area.	**I.J.** The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working relationships with key health and social services providers. The provider has on file a current MOU with each HMO in the county.

GUIDELINE	PERFORMANCE MEASUREMENT
I.K. Establish written procedures regarding the release of recipient-specific information. Recipients may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the recipient.	**I.K.** The provider has written policies regarding the release of recipient-specific information. The policies specifically address the release of sensitive information.

II. PREGNANCY QUESTIONNAIRE ADMINISTRATION

The provider must administer the Medicaid-approved assessment tool (the Pregnancy Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the recipient's strengths and needs. In addition to the Pregnancy Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

Providers may consult the Guidance Manual for Administering the Prenatal Care Coordination Pregnancy Questionnaire for detailed information on administering the questionnaire. Refer to Appendix 16 for information on obtaining the Guidance Manual for the Pregnancy Questionnaire.

All recipients must have a completed copy of the Pregnancy Questionnaire in their file.

Note: The Pregnancy Questionnaire includes several questions to which the recipient may object. Prior to administering the Pregnancy Questionnaire, explain the assessment and care planning process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the recipient, including who will have access to the information provided.

GUIDELINE

The provider must:

II.A. Administer and score the Pregnancy Questionnaire in its entirety unless the recipient objects to a particular question or section, or the information is unavailable.

II.B. Review and finalize the Pregnancy Questionnaire in a face-to-face meeting with the recipient. The staff completing the Pregnancy Questionnaire must sign and date it. A qualified professional must review and sign all Pregnancy Questionnaires completed by paraprofessional staff.

II.C. Inform recipients who score 40 or more points on the Pregnancy Questionnaire that they are eligible to receive PNCC services.

If the recipient is not interested in receiving services, try to determine the reason. Give the recipient a written copy of the agency's address and telephone number and ask the recipient to call or stop by if she changes her mind.

II.D. Inform recipients who score less than 40 points on the Pregnancy Questionnaire that they are not eligible to receive PNCC services.

Based on the recipient's identified needs, refer her to other community resources as appropriate. Give the recipient a written copy of the agency's telephone

PERFORMANCE MEASUREMENT

II.A. The recipient's file includes a completed and scored Pregnancy Questionnaire. If the questionnaire is not completed in its entirety, there is documentation that explains why.

II.B. The recipient's file includes documentation that the Pregnancy Questionnaire was reviewed and finalized in a face-to-face visit. The Pregnancy Questionnaire is signed and dated. The recipient's file also includes documentation that a qualified professional reviewed and signed all Pregnancy Questionnaires completed by paraprofessional staff.

II.C. The recipient's file documents that the recipient was offered PNCC services.

If the recipient is not interested in receiving services, the reason is documented. The file includes documentation that the recipient received a written copy of the provider's address and telephone number and was asked to call if she changes her mind about receiving services.

II.D. The recipient's file includes documentation that the recipient was referred to other community resources as appropriate. The file also documents that the recipient was asked to contact the provider if she has a significant negative change in her family, medical, social, or economic status while she is still pregnant.

GUIDELINE (II.D. Cont.)	PERFORMANCE MEASUREMENT (II.D. Cont.)
number and ask her to call or stop by if she has a significant negative change in her family, medical, social, or economic status while she is still pregnant. Also, the provider may reassess the recipient if someone, such as a health care professional, a school, or a social worker, refers her back to the provider. The provider may use the same Pregnancy Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Pregnancy Questionnaire must be clearly identified (for example, use a different color of ink, cross out old response). Do not erase or totally obliterate the original response. Re-sign and date the Pregnancy Questionnaire.	Changes to the Pregnancy Questionnaire are legible and clearly identified. The Pregnancy Questionnaire is signed and dated.
II.E. Use a new Pregnancy Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The recipient's file includes a new Pregnancy Questionnaire if more than 12 months have elapsed since the initial assessment.

III. CARE PLAN DEVELOPMENT

The Pregnancy Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Pregnancy Questionnaire.

GUIDELINE	PERFORMANCE MEASUREMENT
The provider must:	
III.A. Develop a written individualized care plan for each recipient scoring 40 or more points on the Pregnancy Questionnaire. Develop only one care plan for each recipient.	**III.A.** The recipient's file includes an individualized care plan if the recipient scored 40 or more points on the Pregnancy Questionnaire.
III.B. Include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate.	**III.B.** The recipient's file includes documentation that the recipient and, when appropriate, the recipient's family and other supportive persons actively participated in the development of the care plan.
The recipient and provider who developed the care plan must sign and date the plan.	The recipient and the provider have signed and dated the care plan.
III.C. Inform the recipient that the care plan can be changed at any time, and as often as necessary. Provide the recipient with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The recipient's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: • Identification and prioritization of all strengths and problems identified during the initial assessment, including those related to health and nutrition education. • Identification and prioritization of all services to be arranged with the recipient, including the names of the service providers (including health care providers). • A description of the recipient's informal support system, including collaterals, and activities planned to strengthen it if necessary. • Appropriate referrals and planned follow up. • Expected outcome of each referral. • Progress or resolution of identified priorities. • Documentation of unmet needs and gaps in service. • Planned frequency, time, and place of contacts with the recipient.	**III.D.** The recipient's file includes a care plan that meets the stated guidelines.

GUIDELINE (III.D. Cont.)	PERFORMANCE MEASUREMENT
• Identification of individuals who participated in the care plan development. • The recipient's responsibility in the plan's implementation. If there are other care coordinators involved with the recipient, the care plan must address any needed collaboration or coordination. This requirement applies whether or not Medicaid covers the other care coordinators' services. The recipient's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.	
III.E. At a minimum, review and update the recipient's care plan every 60 days or sooner if the recipient's needs change. If necessary, update the recipient's care plan during each visit. All updates to the care plan must be signed or initialed and dated by the provider and the recipient.	**III.E.** The recipient's file includes documentation that the care plan was updated at least every 60 days. All updates to the care plan are signed or initialed and dated by the provider and the recipient.
III.F. Provide the recipient with the written name and telephone number of: • The person who will provide the ongoing care coordination services. If necessary, introduce the recipient to the care coordinator if he or she is different from the person who administered the assessment and developed the care plan. • The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The recipient's file includes a copy of, or documentation stating that the provider gave to the recipient, written information identifying the name and telephone number of the care coordinator and of the person to contact as back-up.

IV. ONGOING PRENATAL CARE COORDINATION AND MONITORING

All recipients must have a care plan in their file that predates the delivery of ongoing PNCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all recipient and collateral contacts. The documentation must include the following:

- The recipient's name.
- The date of the contact.
- The full name and title of the person who made the contact.
- A clear description of the reason for and nature of the contact.
- The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
- Where or how the contact was made.

Prenatal care coordination ongoing services must be based on the care plan.

GUIDELINE	PERFORMANCE MEASUREMENT
PSYCHOSOCIAL SERVICES The term "psychosocial" refers to those concerns about relationships and support systems, fears about personal safety or safety of other family members, fears about past or current physical or substance abuse, depression or other mental health problems, worries about ability to meet basic needs for food and shelter, and significant stress about ability to cope with the current pregnancy. Psychosocial services should be provided by professional staff who are qualified by education, training, and experience to provide the level of service the recipient needs. Psychosocial services are provided to assist the pregnant woman in: • Resolving relationship problems that may adversely affect her health and the outcome of her pregnancy. • Identifying and accessing other services that will support her efforts to maintain a healthy pregnancy, continue positive health behaviors and provide a safe home for herself and her children. • Understanding and dealing with the social-emotional aspects of pregnancy and parenting. • Evaluating behaviors that may interfere with having a healthy pregnancy and infant, such as substance abuse, poor nutrition, and high-risk sexual behavior.	

GUIDELINE	PERFORMANCE MEASUREMENT
IV.A. On an ongoing basis, the provider must: • Determine which services identified in the care plan have been or are being delivered. • Determine if the services are adequate for the recipient's needs. • Provide supportive contact to ensure that the recipient is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. • Monitor the recipient's satisfaction with the service. • Ask the recipient to evaluate the quality, relevance, and desirability of the services to which she has been referred. • Identify changes in the recipient's circumstances that would require an adjustment in the care plan.	**IV.A.** The recipient's file includes documentation that indicates the provider offered ongoing services as stated.
IV.B. Provide the recipient with information on community resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals must include: • The care coordinator's name, address, and telephone number. • The recipient's name. • The date that the referral is made. • The name, address, and telephone number of the agency/provider to which the recipient is being referred. • The reason for the referral.	**IV.B.** The recipient's file indicates that the provider made available information on community resources and provided referrals as appropriate. A copy of all written referrals is maintained (or noted, if verbal) in the recipient's file.
IV.C. When referring the recipient for services, the care coordinator must: • Ensure that the recipient understands the reason and need for the referral. • Inform the recipient of all available options for obtaining the needed service. • Explain any costs involved or limitation in the service. • Assist the recipient in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address.	**IV.C.** The recipient's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow-up on all referrals with the recipient and the service provider.

GUIDELINE (IV.C. Cont.)	PERFORMANCE MEASUREMENT
• Follow up with the service agency, including appropriate advocacy on behalf of the recipient to ensure that services are provided. Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	
IV.D. Ensure that the intensity and frequency of contacts with the recipient corresponds to the level of need and/or risk identified by the Pregnancy Questionnaire. For example, schedule frequent face-to-face visits if the recipient is in crisis, if there is violence in the home, or if the recipient is a first-time parent with no support system. If necessary, call or visit the recipient daily or weekly. At a minimum, contacts or visits should occur no less than every 30 days. If possible, schedule more frequent visits during the early months of pregnancy.	**IV.D.** The recipient's file includes documentation that contacts with the recipient correspond to the level of need/risk and includes the date, time, location, and length of recipient contact, progress and/or resolution of identified problems, and signature of the professional reviewer. The recipient's file includes documentation supporting contacts with the recipient that are less frequent than the stated guidelines.
IV.E. Assist the recipient in accessing and appropriately using the health care delivery system. For example, ensure that the recipient: • Can identify her primary/obstetric care provider, clinic, and HMO. • Has her health care providers' telephone numbers and addresses and knows where to find them. • Knows the proper procedures for obtaining medical information or health care after hours. • Understands how to obtain specialty care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment. • Knows when to use the hospital emergency room. • Knows how to schedule, reschedule, and cancel appointments. Assist the recipient in obtaining information as appropriate.	**IV.E.** The recipient's file includes documentation of the recipient's knowledge, deficiencies, and information provided as stated in the guidelines.
IV.F. Refer the recipient for counseling and support in the grief process when there is an early pregnancy loss (before 20 weeks gestation).	**IV.F**. The recipient's file includes documentation and follow up on the referral.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.G. If the recipient indicates a desire to have an elective abortion, refer her to an appropriate medical provider for counseling. Inform the recipient that Wisconsin Medicaid does not cover care coordination services following an elective abortion.	**IV.G.** The recipient's file includes documentation of the referral.
IV.H. Refer recipients with complex psychosocial needs to additional community or mental health services. If the recipient exhibits behavior that may be dangerous to herself or others, immediately refer her to her health care or mental health provider in the community. Ensure follow up within 24 hours.	**IV.H.** The recipient's file includes appropriate referrals and documentation of timely follow-up on the referrals. Recipient's file also documents follow-up within 24 hours, if appropriate.
IV.I. Reassess the recipient's psychosocial risk status at least once each trimester and update the care plan as necessary. The assessment should include the recipient's strengths, weaknesses, support system, environment, actual and potential stressors, attitude toward the pregnancy, and past experiences with pregnancy.	**IV.I.** The recipient's file includes documentation of a periodic assessment. The care plan is updated as necessary.

V. NUTRITION COUNSELING

Wisconsin Medicaid covers nutrition counseling if the need for it is identified in the Pregnancy Questionnaire and it is included in the recipient's individualized care plan. Pregnant women identified with nutrition-related needs may require a more in-depth nutritional assessment, nutrition education, and counseling by a registered/certified dietitian or other qualified professional.

GUIDELINE

V.A. Assess the recipient's knowledge and understanding of basic nutrition and dietary practices and how these factors could affect the pregnancy outcome for both her and the fetus. If possible, conduct the assessment during the first visit. Ensure that the care plan addresses the recipient's specific education needs.

Provide or refer the recipient for education on the following topics as needed:

- Recommended weight gain and weight gain goals.
- Recommended dietary intake and meal patterns.
- Suggestions to improve intake of:
  - √ Calcium-rich foods.
  - √ Iron-rich foods and foods that enhance iron absorption.
  - √ Folate-rich foods.
- Use of vitamin and mineral supplements and over-the-counter medicines.
- Avoidance of self-imposed diets and food practices that can be harmful.
- Dietary interventions for common problems of pregnancy:
  - √ Nausea and vomiting in early pregnancy.
  - √ Heartburn.
  - √ Constipation.
- Promotion and support of breastfeeding.
- Resources for food, food budgeting, preparation, and storage, including referral and follow up on WIC Program participation.
- Safe water source: refer for testing if lead, nitrates, or fluoride level might be a problem, and refer for dietary fluoride supplements when necessary.

PERFORMANCE MEASUREMENT

V.A. The recipient's file includes documentation of the assessment. The recipient's care plan addresses the recipient's specific education needs. A check-off list is permissible.

GUIDELINE	PERFORMANCE MEASUREMENT
V.B. Conduct periodic reassessments throughout the pregnancy. All assessments must be signed and dated.	**V.B.** The recipient's file includes documentation of periodic reassessments. The assessments are signed and dated.
V.C. Refer recipients with more intensive nutritional-related needs to a dietitian if necessary. Problems indicating a need for referral to a registered/certified dietitian include but are not limited to: • Pre-pregnancy weight less than 20 Body Mass Index (BMI). • Pre-pregnancy weight greater than 26.0 BMI. • Inappropriate weight gain based on weight gain recommendations of the Institute of Medicine, 1990. • Anemia: hematocrit < 30.0%, or hemoglobin < 10.0 g/dL. • Pregnant woman's own history of childhood lead poisoning, or current blood lead level > 10 ug/dL within the last 12 months. • Previous obstetrical complications: anemia, pregnancy-induced hypertension, fetal loss, premature delivery, inadequate weight gain, low-birth-weight infant, small-for-gestational-age infant, high-birth-weight infant. • Current medical/obstetrical complications: diabetes, hypertension, renal disease, liver disease, cancer, cardiopulmonary disease, PKU, thyroid disease, gastrointestinal disease (e.g., parasites, short gut), hyperemesis gravidarum, severe infection, anesthesia/surgery/trauma within six months. • Psychological problems: current or past history of eating disorders, depression influencing appetite or eating, mental retardation, mental illness. • Dietary factors: inadequate diet, milk allergy, lactose intolerance, self-imposed dietary restrictions, inappropriate use of supplements and over-the-counter medications, insufficient resources to obtain, store, and prepare food to achieve an adequate dietary intake. • Age 17 years or less at time of conception. • 16 months or less between end of last pregnancy and conception. • Multiple gestation. • Smokes, uses alcohol or illicit drugs. • Breastfeeding another child during current pregnancy. • Pica (eating nonfood substances).	**V.C.** The recipient's file includes documentation of the specific reasons for referral to a registered/certified dietitian. The file also includes documentation of timely follow up with the dietitian to ensure the recipient is receiving nutrition care.

GUIDELINE	PERFORMANCE MEASUREMENT
V.D. Ensure that printed booklets and handouts obtained for distribution to recipients are appropriate for recipient's reading level and culture.	**V.D.** The provider has printed nutritional material that is appropriate for its target population.

VI. BASIC HEALTH INFORMATION AND HEALTH EDUCATION

Wisconsin Medicaid covers health education if the need for it is identified in the Pregnancy Questionnaire and it is included in the recipient's individualized care plan. Pregnant women identified with health education-related needs may require in-depth health education and counseling by a qualified professional.

GUIDELINE

VI.A. Assess the recipient's knowledge and understanding about her medical status and health practices and the impact on her pregnancy outcome.

Reassess the recipient periodically and provide ongoing education if necessary.

VI.B. Ensure the recipient's care plan includes the identified health education needs, strategies for addressing them, and reasonable goals.

VI.C. Provide basic health information to the recipient. Ensure that the information is easy to understand, culturally appropriate, and shared in a non-threatening and non-judgmental manner.

The intent of providing basic information about pregnancy is to help the woman positively adjust to her new condition. At this level the emphasis is not on behavior or lifestyle change but information sharing. Basic health information about prenatal care and pregnancy could include the following topics:

- Importance of continuous prenatal care.
- Normal changes due to pregnancy as it relates to each trimester.
  - √ Maternal anatomy and physiology.
  - √ Fetal development.
  - √ Emotional issues.
- Self-help strategies for common discomforts related to pregnancy.
- Self-care during pregnancy.
- Pregnancy complications.
  - √ Symptoms and self-detection of preterm labor.
  - √ Bleeding, infections during pregnancy, rupture of the bag of waters.
  - √ Emergency arrangements.

PERFORMANCE MEASUREMENT

VI.A. The recipient's file includes documentation of the assessment. A check-off list is permissible if it identifies specific educational areas of need.

The recipient's file also includes documentation of periodic reassessments.

VI.B. The recipient's care plan addresses identified needs, strategies for addressing them, and reasonable goals.

VI.C. The recipient's file includes documentation of the information provided.

GUIDELINE	PERFORMANCE MEASUREMENT
(VI.C. Cont.) • Understanding the dangers of over-the-counter medicines, prescription drugs, tobacco, alcohol, illicit drug use, and environmental and occupational hazards as they relate to pregnancy. • Preparation for labor, delivery, and postpartum discharge: √ Hospital arrangements. √ Support person to participate during labor and delivery. • Preparation for the baby. • Infant care, including nutrition and breastfeeding. • Family Planning.	
VI.D. Provide or refer recipients for in-depth health education services if necessary. Ensure that the educational interventions address those high-risk medical conditions and health behaviors that can be alleviated or improved through education. Include the following topics as appropriate: • Education/assistance to stop smoking. √ Decrease smoking alternative. √ Effects of smoking on mother and fetal development. • Education/assistance to stop alcohol consumption. √ Emphasize importance of no alcohol during pregnancy. √ Effect of alcohol on fetal development. • Education/assistance to stop use of illicit or street drugs. √ Emphasize no safe limit. √ Effects of drugs on fetal development. • Education/assistance to stop high-risk sex practices. • Education on the safe use of over-the-counter/ prescription drugs. • Education on environmental/occupational hazards related to pregnancy. √ Potential exposure to hazard in recipient's own environment. √ Effects on fetal growth and development. √ Efforts to minimize exposure. • Lifestyle management. √ Relaxation techniques. √ Building self-esteem.	**VI.D.** The recipient's file must include documentation of the need for more in-depth education. The file must also describe the type of education provided and the recipient's progress in meeting established goals. The file includes documentation of follow-up on referrals.

GUIDELINE	PERFORMANCE MEASUREMENT
(VI.D. Cont.) √ Learning coping strategies and decision-making skills. √ Communication skills with health care providers, family, peers, etc. • Reproductive health. √ Human sexuality. √ Environmental/occupational hazards. • Anticipatory guidance on childbirth, health and child growth and development. Refer the recipient for additional support or information as needed. Ensure timely follow up on all referrals.	
VI.E. Ensure that printed booklets and handouts obtained for distribution to recipients are appropriate for recipients' reading level and culture.	**VI.E.** The provider has printed material that is appropriate for its target population.

VII. POSTPARTUM SERVICES

Prenatal care coordination services continue during the postpartum period (the first 60 days following delivery).

GUIDELINE	PERFORMANCE MEASUREMENT
During the postpartum period, providers should:	
VII.A. Make at least one face-to-face contact. If possible, make at least one home visit.	**VII.A.** The recipient's file includes documentation of the contact.
VII.B. Update the recipient's care plan within 30 days after delivery. Address any negative changes in the recipient's postpartum medical and/or psychosocial condition with the recipient.	**VII.B.** The recipient's file indicates any necessary updates and follow-ups.
VII.C. Refer the recipient for counseling and support if she has a stillbirth. Ensure timely follow up on the referral.	**VII.C.** The recipient's file includes documentation of the referral and follow-up.
VII.D. Refer the recipient to the Infant Death Center of Wisconsin if there is a sudden, unexpected infant death. Ensure timely follow up on the referral.	**VII.D.** The recipient's file includes documentation of the referral and follow-up.
VII.E. Refer the recipient for additional support and assistance in learning how to care for her child if the child is identified as having a special health care need (for example, spina bifida, cleft lip, cerebral palsy) or a medical risk condition (for example, low birth weight, prematurity). Ensure timely follow up.	**VII.E.** The recipient's file includes documentation of the identified problem, referrals, and follow-up.
VII.F. Assess the recipient's knowledge and understanding of basic postpartum care. Provide information as necessary. At a minimum, include the following topics in the assessment: • Personal hygiene. • Nutrition during breastfeeding, including influence of tobacco, alcohol, and other drugs. • Postpartum nutrition if formula feeding. • Guides to successful breastfeeding, breast care, and routine self-breast checks. • Physical activity and exercise. • Recognition of minor gynecologic problems. • Family planning. • Prevention of sexually transmitted diseases. • Continuity of basic primary and reproductive health care.	**VII.F.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
VII.G. Assess the recipient's interpersonal relationship with the infant. The assessment could include the recipient's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant, and past experiences with parenting. Refer the recipient as appropriate.	**VII.G.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.
VII.H. Assess the recipient's knowledge and understanding regarding appropriate newborn care and feeding practices and how these factors affect growth and development. Provide information or refer the recipient to a qualified professional as appropriate. At a minimum, include the following topics in your assessment: • Infant's hunger and fullness cues. • Infant nutrition and appropriate feeding practices. • Successful breastfeeding. • Food and/or formula preparation and storage. • Bathing, skin and cord care, and diaper rash prevention. • Normal growth and development. • Taking infant's temperature, treatment of nausea, vomiting, dehydration, and fever. • Infant nurturing and stimulation. • Effects of secondhand smoke on infant health and nutrition. • Injury prevention and safety, including car seats, falls, poisoning, choking, sleep positions. • Appropriate use of infant's primary health care provider versus the emergency room.	**VII.H.** The recipient's file includes documentation of the assessment, information or referral provided, and any follow-up.
VII.I. Encourage the recipient to choose a primary health care provider for the baby. Assist her in obtaining information regarding appropriate providers. Refer her to her HMO if appropriate.	**VII.I.** The recipient's file includes documentation of the referral and follow-up.
VII.J. Inform the mother about the importance of timely immunization and regular well-child checkups. Assist her with making initial appointments, if needed.	**VII.J.** The recipient's file includes documentation of information provided, referrals given, and follow-up.
VII.K. Assess the recipient's knowledge of the steps involved in obtaining appropriate and reliable child care.	**VII.K.** The recipient's file includes documentation of the assessment, information provided, referrals given, and follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
(VII.K. Cont.) Provide information or refer the recipient for assistance if deficiencies are found in the following areas: • Knowledge regarding available resources for checking provider references. • Evaluating child care settings for safety. • Obtaining financial assistance for child care. • Appropriate monitoring of the child care provider. • Reporting suspected child abuse or neglect by the child care provider.	
VII.L. Refer women who require services beyond the postpartum period to other community resources before discharge from the PNCC program. Follow up on any referrals prior to the 60th day after delivery. Document the last date of service (the date the recipient is discharged).	**VII.L.** The recipient's file includes documentation of PNCC postpartum contacts, referrals, follow-up, and discharge from the program. The recipient's file also indicates the date of delivery.